Post Traumatic Stress Disorder Revisited

Lanny Snodgrass, MD, PhD
VA Puget Sound Health Care Services
Clinical Assistant Professor,
University of Washington, School of Medicine
Department of Psychiatry and Behavioral Science
Teaching Faculty, Madigan Army Medical Center

“Until you can prove it’s service related, there’s nothing we can do.”

"This subject (the traumatic neurosis) has been submitted to a good deal of capriciousness in public interest. The public does not sustain its interest, and neither does psychiatry. Hence, these conditions are not subject to continuous study, but only to periodic efforts which cannot be characterized as very diligent. Though not true in psychiatry generally, it is a deplorable fact that each investigator who undertakes to study these conditions consider it his sacred obligation to start from scratch and work at the problem as if no one had ever done anything with it before.""

(Kardiner and Spregel, 1947)

DSM IV Definition

A. The person has been exposed to a traumatic event in which both of the following were present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others

(2) the person's response involved intense fear, helplessness or horror. *Note: In children, this may be expressed instead by disorganized or agitated behavior.*

DSM IV Definition

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: IN young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content

(3) acting or feeling as if the traumatic event were recurring. Note: In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

DSM IV Definition

C. Of general responsiveness, as indicated by three or more of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g. unable to have loving feelings)

(7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

DSM IV Definition

D. Persistent symptoms of increased arousal, as indicated by two or more of the following:

(1) difficulty falling or staying asleep
(2) irritability or outbursts of anger
(3) difficulty concentrating
(4) hypervigilance
(5) exaggerated startle response

E. Duration of the disturbance is more than 1 month

THE DISTURBANCE CAUSES CLINICALLY SIGNIFICANT DISTRESS OR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING

DSM IV Definition

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor.

PTSD DSM-IV
Diagnostic Criteria-- Overview

A. The person has been **exposed** to a traumatic event

B. The traumatic event is persistently **reexperienced**

C. Persistent **avoidance** of stimuli associated with the traumatic event and numbing of general responsiveness

D. Persistent symptoms of **hyperarousal** not present before the traumatic event

E. Symptoms duration of criteria B, C and D is **more than 1 month**

F. Symptoms cause clinically significant **distress** or **impairment** at home, work, or in other areas of functioning

PTSD Prevalence

- **5th most prevalent major psychiatric illness**

Incidence of suicide attempts among PTSD patients as high as 20%

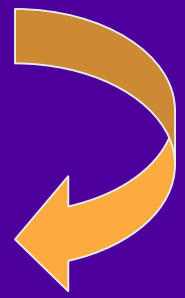
- 39% of women with aggravated assault
- 35% of women who were raped (Kilpatrick, Resnick, 1993)
- Rape victims reported a PTSD lifetime prevalence of 80%

(similar to study by Ruthbaum et al, 1992)

- Male Vietnam combat veteran 31% lifetime prevalence
  -Half of these veterans continued to meet full criteria 20 yrs after the war
- ***WWII POWs show a lifetime rate of 50%*** **(Speed et al, 1989)**

PTSD Prevalence (Cont'd.)

- Research study of combat-related PTSD in a nonpsychotic population at the West Los Angeles VA Medical Center.
  - Out of 40 Vietnam-era combat veterans with a negative history of seeking psychiatric help for PTSD, 20 met DSM criteria for PTSD



- Results: The PTSD positive veterans differed from the rest of the sample on two strategic parameters:
  1. Higher incidence of substance abuse while in Vietnam
  2. A greater number of negative homecoming experiences* characterized this group of PTSD-positive subjects.

*greater amount of cynicism, alienation, physical neglect, demeaning experiences during first 6 months of homecoming

Common Traumatic Events
(National Comorbidity Survey)

- Witnessing injury/death
- Sexual molestation/rape
- Natural disaster/fire
- Physical attack/abuse/threatened with a weapon
- Life-threatening accident
- Combat
- Shock

Events leading to PTSD

- Experiencing, witnessing,or learning of actual or threatened death
- Serious injury to oneself or others that directly results in intense fear, helplessness or horror
- **Strongest predictor: duration of combat exposure**
- **2nd strongest predictor: abusive childhood**

Individual Variations of those who Develop PTSD

1. Among VN War veterans level of exposure to combat and abusive violence is associated at higher rates of PTSD (Fairbank et al, 1993)

2. Monozygotic twin studies (one who served in VN and one who did not) – strong effect to exposure to combat. (Goldberg et al.. 1990)

3. Other Genetic contributions: Intrusive synptoms of PTSD are related to Level of combat; emotional numbing symptoms show lower relationships With combat and are more strongly explained by genetic factors

4. Other risk factor; socioeconomic status during developing years, psychiatric Symptom prior to exposure, and childhood abuse. (Kulka et al. 1990 N=1500 VN Vets)

Individual variations of those who develop PTSD Cont..

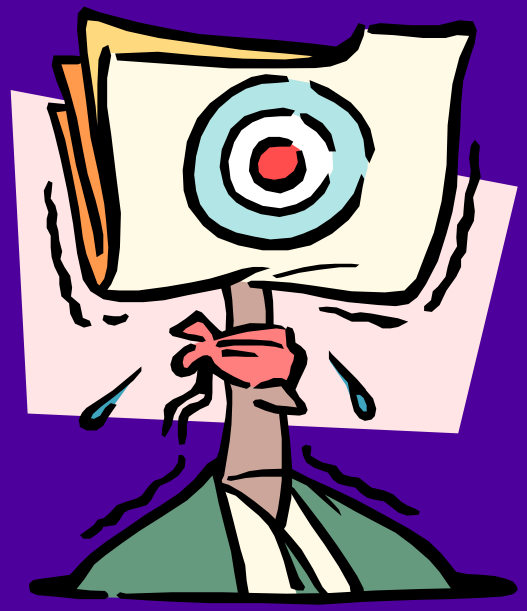
- Precrime depression may represent vulnerability for development of PTSD under condition of exposure to high crime stress. (Resnick et al. 1992)

6. Disaster research reveals that nearly all of these studies that examined Exposure intensity show the level of exposure predictive of outcome with prior psychiatric history increasing the risk of post disaster symptoms.

(Green and Solomon. 1996)

Some Neurobiological Issues of PTSD

It was British psychiatrist Charles Samuel Myers who originated the term “shell shock” during World War I and proposed that the essence of traumatization is that individuals are unable to integrate it into their normal personality states, *“…the normal has been replaced by what we may call the ‘emotional personality.’*



Some Neurobiological Issues of PTSD (cont..)

Henry Krystal (1978)

- Trauma results in loss of ability to identify specific emotions to serve as a guide to taking appropriate actions
- The inability to create semantics to identify somatic states is related to the development of psychosomatic reactions and to aggression against self and others

Positron Emission Tomography (PET) Scan

- Showed increase in perfusion of the areas in the right hemisphere when exposed to stimuli reminiscent of their trauma
- Simultaneous decrease in oxygen utilization in Broca's area (region responsible for generating words to attach to internal experience)

Results from these findings may account for trauma leading to speechless terror, which in some individuals interferes with their ability to put feelings into words.

Some Neurobiological Issues of PTSD cont..

Pitmann and Orr (1990)

- In traumatized organisms, they access trauma-related memory traces too readily, and thus they tend to "remember" the trauma easily – especially when it is irrelevant to their current experience

Norepinephrine (NE) input into the amygdala determines how potent a memory trace is laid down (LeDoux 1990)

Van der Kolk, et al (1996)

- The difficulty which PTSD patients face in managing emotions interfering with the capacity to work through ordinary problems and conflicts is because people with PTSD either avoid emotional entanglements or fail to modulate the extent of their involvement and often fail to build up a store of gratifying experiences and therefore are deprived of those psychological rewards that allow most people to cope with the injuries of everyday life, thus keeping them preoccupied with the trauma at the expense of getting satisfaction out of daily life.

Treatment of PTSD

Aim of Therapy:

1. Help them move from being haunted by the past and interpreting emotionally arousing stimuli as a return of the trauma, to being fully engaged in the present and becoming capable of responding to current exigencies.

2. The integration of the alien, the unacceptable, the terrifying and Incomprehensible into their self-concepts; integrated as aspects of the Individual's history and life experiences (Van der Kolk & Ducey)

Treatment of PTSD cont..

Psychotherapy should address:

1. Deconditioning of anxiety
2. Altering the way the victim views his/her self and their world by reestablishing a feeling of personal integrity and control

Treatment of PTSD cont..

Therapeutic relationship:

1. Complex, e.g., interpersonal aspects of the trauma (mistrust, betrayal, dependency,, love, hate) tend to be replayed within the therapeutic dyad.

2. Therapy confronts individuals with intense emotional experiences ranging from helplessness to intense wishes for revenge and from vicarious traumatization to vicarious thrills.

Treatment of PTSD cont..

Psychopharmaco-therapy

1. Anti-depressants
2. Mood Stabilizers
3. Anti-psychotics
4. Anxiolytics

Treatment cont..

Treatment proceeds in phases: (Van der Hart et al advocate of phase-oriented treatment of PTSD)

1. **Stabilization**: education and identification of feelings through verbalizing somatic states.
2. **Deconditioning** of traumatic memories and emotional repsonse
3. **Restructuring** of personal traumatic schemes
4. **Reestablishment** of secure/trustful social connections and interpersonal efficacy.
2. Accumulate **restitutive** emotional experiences.